SYDNEY **Unappetising choice faces Australian voters**

The Minister for Health and Human Services, Carmen Lawrence, has had a terrible year, leading up to the March 2 federal elections. A former premier of Western Australia, and a state cabinet minister at the time of enormous government financial mismanagement and some corruption, Lawrence was sanctified when she transferred to the federal sphere.

But the halo was crushed by the Easton affair. When Lawrence was Western Australia's premier, a member of her government tabled documents aimed at discrediting the then opposition leader, Richard Court. Also hurt by the documents was Penny Easton, a lawyer, who killed herself 2 days later. Lawrence consistently denied she knew anything of the documents until they were tabled, but a Royal Commission called by Court when he became premier found that she had lied. Although she survived as minister, a "Carmen" has become a synonym for a lie. Her credibility with most of the public has gone they way of the *Titanic,* and her sallies into health policy have not made a huge impression.

The Liberal/National Coalition also has an appalling record on health policy. From 1977 to 1983, it dismantled Australia's first national health-insurance scheme, Medibank. It spent the next decade in opposition, promising to do the same to Medibank's successor, Medicare. It developed policies that clearly did not add up, boosted the incomes of doctors at the expense of patients, or were intrinsically unappealing to voters. In one election, it ran without a health policy at all.

The policies released in the past 10 days offer little to differentiate the parties. Both have offered fairly small sums of money—from the Labor Party up to A$500 annually for most families with two children and from the Coalition up to $450 annually for most families with dependants—to encourage people into private health insurance. Both sides have promised to boost rural health by encouraging more doctors to practise in the bush. Both have promised more efficiency in the health system, without really saying how it will be achieved.

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On top of that, the Coalition has promised to give greater emphasis to promoting health, preventing illness, and promoting primary health care. But this emphasis on prevention does not extend to tightening regulations on tobacco marketing and packaging, and the Coalition policy states that tobacco excise will not be increased. The largest preventable cause of ill health has become an untouchable.

This is probably the most attractive health policy the Coalition has released in 13 years, but that's not saying much. It's a sign of how little the Coalition is trusted that the first three lines of the policy are devoted to reassuring us, the voters, about the things it will not destroy—Medicare, bulk billing, and community rating in health insurance.

Health policy aside, it will be an unappetising choice on March 2. The Prime Minister, Paul Keating, is a complex man who inspires simultaneous respect and distaste for his vitriol, his passion, his rhetoric, his arrogance, his vision, his humour, and his disparagement of anyone who dares differ from the Keating worldview. The Coalition leader, John Howard, is a drab man whose previous strong policy positions have evaporated in the pursuit of power. We, the public, are impressed with neither.

And those interested in health are faced with a choice between a bored and distracted government that is satisfied with the current system, and an opposition that can see a problem, but cannot find a decent solution.

Mark Ragg

LUCCA **Designs on pharmacovigilance in Italy**

At first glance, the paucity of adverse drug reactions (ADR) reported in Italy might suggest that we prescribe fewer or safer drugs here. The truth is less cheering; although spontaneous ADR reporting has been compulsory by law since 1987, widespread underreporting, with a few possible exceptions, practically cripples the pharmacovigilance system.

In the UK, Germany, and France 15 to 20 ADRs are reported each year per 100 000 inhabitants. The figure for Italy is about five, making the total number of reports collected each year, between 1989 and 1993, only 2000 to 3000.

Fewer than 1% of doctors here have ever reported an ADR. Reasons for the underreporting include: the ill-founded belief that existing drugs are safe, guilt at having prescribed a toxic drug, fear of legal repercussions, poor reporting instructions, lack of feedback from centres gathering reports, and indifference.

Concerned by this sorry state, an expert group is promoting its draft proposals for improvement. They want to see a network of regional centres that would collect local ADR data and encourage futher reporting. Giampaolo Velo, a member of the expert group, is head of Verona University's department of pharmacology and clinical pharmacology unit, where an efficient pharmacovigilance centre has been in operation since 1987. He says that there would be a significant impact on spontaneous reporting if regional centres were to supply more and better data on drug safety back to doctors.

Linked to a network of regional centres, the proposal includes a reshaped national pharmacovigilance centre and a new commission, both of which should be in the Health Ministry, and a scientific coordinating centre at the Instituto Superiore di Sanità in Rome.

Might these ambitious plans simply represent duplication complication of the existing system? Italian doctors, who tend to regard central institutions as distant and unhelpful, might need to be convinced of their value.

Bruno Simini